



DELAWARE HEALTH AND SOCIAL SERVICES  
Division of Substance Abuse and Mental Health  
1901 N. Dupont Highway, New Castle, DE 19720 Phone: (302) 255-2700



# 24 HOUR EMERGENCY ADMISSION FORM

(Treatment shall not exceed 24 Hours)

(Delaware Code: Title 16, Chapter 50, Section 5122 as Amended 7/92)

STATEMENTS 1, 2, AND 3A MUST BE COMPLETED BEFORE THIS FORM IS PRESENTED TO THE ADMITTING PHYSICIAN:

## 1. STATEMENT OF COMPLAINT:

I hereby certify that I have knowledge that \_\_\_\_\_  
(Name of person to be admitted)

of \_\_\_\_\_  
(Street address, city, state)

appears to have a mental illness and is likely to be in danger of hurting him or herself, or others, and requires immediate care, treatment, or restraint. I certify this because:

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### Additional Information:

History of prior psychiatric hospitalizations: Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

If yes, when and where was the most recent admission: \_\_\_\_\_

Prior or current substance abuse or psychiatric treatment: Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

If yes, where, and therapist's name and phone number: \_\_\_\_\_

Current substance abuse: Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

If yes, what and when last used: \_\_\_\_\_

### **Danger to self and others includes, but is not limited to, the following scenarios:**

- Expressing suicidal or homicidal thoughts with a plan and means to carry out the threat.
- Inflicting or attempting to inflict serious bodily harm on themselves or others through overdose or physical means, and there is reasonable probability that such conduct will be repeated.
- Experiencing delusions or thought disturbances that place the person in danger, or puts others in danger.

Relationship or other connection with person to be admitted: \_\_\_\_\_

Name and phone number of spouse or closest relative (if known) of person to be admitted: \_\_\_\_\_

Signature of person making complaint: \_\_\_\_\_ Date and Time: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

## 2. STATEMENT OF PEACE OFFICER:

I have taken \_\_\_\_\_, with all reasonable promptness, to a physician licensed in the State of Delaware to practice medicine or surgery. Describe briefly the circumstances, and your observations about this person and their level of danger, to self or others: \_\_\_\_\_

Signature of Officer: \_\_\_\_\_ Title and Unit: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date and Time: \_\_\_\_\_

## 3. STATEMENT OF EXAMINING PHYSICIAN:

I certify that I am a physician licensed in the State of Delaware to practice medicine or surgery. I certify that I have evaluated \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location of Evaluation: \_\_\_\_\_

### (COMPLETE A or B)

**A.** I find this person has met the standards of "A person who has a mental illness and is likely to be in danger of hurting him or herself, or others, and to require immediate care, treatment, or restraint." (*Give a description of the behavior and symptoms*)

*(Please attach other forms or documents to support your findings)*

Physician Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_  
(Physician must sign and print name)

Physician's Address and Phone Number: \_\_\_\_\_

I have notified the nearest known relative that the person is being taken to: \_\_\_\_\_

Yes \_\_\_\_\_

No \_\_\_\_\_

(This form is to be forwarded to the receiving hospital with the transporting officer or designee)

**B.** I find this person has **NOT** met the standards of “A person who has a mental illness and is likely to be in danger of hurting him or herself, or others, and to require immediate care, treatment, or restraint.” *(Give a description of the behavior and symptoms)*

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**What if any disposition plans were provided to this person upon discharge:**

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*(Please attach other forms or documents to support your findings)*

Physician Signature:\_\_\_\_\_ Print Name:\_\_\_\_\_  
(Physician must sign and print name)

Physician's Address and Phone Number:\_\_\_\_\_

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I have notified the nearest known relative that the person has been released:

Yes\_\_\_\_\_ No\_\_\_\_\_

**(Fax copy of completed form to DSAMH's Eligibility and Enrollment Unit (302) 255-4416**

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**4. STATEMENT OF PHYSICIAN ADMITTING TO IN-PATIENT FACILITY:**

Nearest known relative notified: Yes\_\_\_\_\_ No\_\_\_\_\_

Comments:\_\_\_\_\_

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**REQUEST FOR TRANSPORTATION REIMBURSEMENT  
FOR PERSONS TREATED UNDER A MENTAL HEALTH COMMITMENT**

(Delaware Code: Title 16, Chapter 50, Section 5122 (e) as Amended 7/92)

**Complaint No:**\_\_\_\_\_ **Date, Time of Complaint:**\_\_\_\_\_

**Name of Dept/Troop#**\_\_\_\_\_

**Address and Phone Number:**\_\_\_\_\_

**Patient Name:**\_\_\_\_\_

**Date and Time of Transport:**\_\_\_\_\_

**Name of Transporting Officer:** \_\_\_\_\_ **IBM#**\_\_\_\_\_

**Name of Second Officer:**\_\_\_\_\_ **IBM#**\_\_\_\_\_

**Client Transported: From:**\_\_\_\_\_

**To:**\_\_\_\_\_ **# of miles**\_\_\_\_\_

**Client Transported: From:**\_\_\_\_\_

**To:**\_\_\_\_\_ **# of miles**\_\_\_\_\_

**Total Miles:**\_\_\_\_\_ **@ \$0.15 = \$**\_\_\_\_\_

**Custody Fee Officer #1 (\$25.00) = \$**\_\_\_\_\_

**Custody Fee Officer #2 (\$15.00) = \$**\_\_\_\_\_

**Total Reimbursement Requested: = \$**\_\_\_\_\_

**I hereby certify that the information on this Reimbursement Form is complete and accurate, and that the above-mentioned patient has been transported to the designated receiving facility in accordance with the Delaware Mental Health Commitment Code.**

**Name of Officer Completing this Form:**\_\_\_\_\_

**Signature:**\_\_\_\_\_ **Title and Unit:**\_\_\_\_\_

**Print Name:**\_\_\_\_\_ **Date and Time:**\_\_\_\_\_

Please fax this form at time of service to:  
DSAMH's Eligibility and Enrollment Unit  
14 Central Avenue, New Castle, DE 19720  
Fax (302) 255-4416